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Review

White coated healer or black coated executioner: Health professionals and capital punishment

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ABSTRACT

In some countries and some jurisdictions health professionals are involved in the process of capital punishment. Their involvement raises difficult ethical issues and the more so with changing attitudes to, and growing support for, assisted suicide, greater respect for autonomy and more universal promotion of human rights, including those of prisoners. These issues are discussed in relation to the various stages of the capital punishment process from the investigation of a potential capital offence to the removal of executed prisoners' tissues and organs for transplantation. It is suggested that some of the ethical difficulties can be resolved, or at least ameliorated, by having regard to the three core concepts of medical ethics: autonomy, best interests and rights. But active involvement of health professionals in capital punishment, however justified ethically, runs the risk that 'reforms' will even more deeply entrench what remains of the death penalty, thus making it more resistant to complete repeal.

1. Introduction

It will soon be twenty years since Eastman and McInerney[1] published their influential paper on the ethical aspects of psychiatrists' involvement in capital punishment. The purpose of this paper is to re-examine some of the dilemmas they identified in the light of recent developments in medical ethics and to use their framework to apply similar ethical considerations to the involvement in capital punishment of health professionals in general and with particular regard to the current debate about assisted suicide. It will be suggested, for example, that there is now an urgent need for discussion about the condemned prisoner's right to die with dignity and about whether or not health professionals have a duty to use their professional skills to make executions more humane by minimising the risk of suffering.

These are important considerations because more than a half of the world's population lives in eight countries that still use capital punishment.[2] The methods used by most countries that retain the death penalty are hanging and shooting, in countries governed by *Shari'a* law stoning is common and the most common method in Saudi Ariabia is beheading by sword.[3] In the U.S.A., in addition to hanging and shooting, laws permit execution by lethal gas, lethal injection and electrocution.[4]

2. Ethics and the participation by health professionals in the process of capital punishment

The ethical basis for the prohibition against physician participation in capital punishment has been traced back to The Oath of Hippocrates:

> *I will use treatment to help the sick according to my ability and judgment, but never with a view to injury or wrong-doing. Neither will I administer a poison to anyone when asked to do so nor will I suggest such a course.*

This is often linked to the axiom *primum non nocere* – 'first do no harm' ('nonmaleficence'). It is therefore held that the participation by physicians in executions "contradicts the dictates of the medical profession by causing harm rather than alleviating pain and suffering".[5]

But doctors face competing demands: on the one hand they are required to fulfil socially or legally prescribed roles as an agent of society and on the other hand they have a responsibility to the patient as a member of the medical profession.[6] However, the autonomous role of physicians and in particular their obligation not to compromise their ethical standards, even when so obliged by

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state laws or regulations, is set out in the Declaration of Geneva (1948) and the International Code of Medical Ethics (1949).[7]

There is further ethical objection on communitarian grounds because "(a) physician's participation in that execution does nothing to promote the moral community of medicine" and "offends the sense of community by prostituting medical knowledge and skills to serve the purposes of the state and its criminal justice system".[8] Because physician involvement in capital punishment runs contrary to the traditional medical virtues, it can be regarded as "subversive to the core of medical ethics"[10] and the use of medical skills antithetical to their role in healing.[9]

The other main guiding principle or tenet of ethical clinical practice is 'beneficence' – the affirmative provision of good. It could be argued that, by ensuring a more 'humane' execution, the physician is doing good and is acting in a compassionate and caring way and not simply doing harm.[4] Some doctors have justified their participation on the basis that it is better that a person should die under proper medical supervision than suffer undue pain at death.[10] Others regard it as their civic duty.[11,12] However, the AMA[5] regards these arguments as not sufficiently compelling.

The prohibitions beg the questions of what is meant by 'participation' and what 'the execution process' means. The ethical dilemmas vary according to the nature of the participation and the stage of the process. Eastman and McInerney[1] have observed that each stage (Box 1) could be conceived in terms of "the closeness of the involvement to the actual procedure of execution", including the degree of indirect or direct involvement in the decision to execute and the degree to which each stage has anything to do with healthcare. They have ordered the stages chronologically and observed that "it may well be that lower numbered stages will tend to go with lesser degrees of involvement, or greater degrees of remoteness". They also observe that the stages differ according to the degree to which the execution is 'inevitable' at a particular stage "so that the extent to which the doctor could potentially influence events away from that result varies".

Box 1. The stages of potential involvement of health professionals in capital punishment (adapted from Eastman N, McInerney T. Psychiatrists and the death penalty: ethical principles and analogies. *Journal of Forensic Psychiatry* 1997; **8**: 583–601)

- Investigation of capital offences
- Assessing competency to stand trial
- Restoring competency to stand trial
- Verdict participation
- Sentencing and psychiatric evidence as to aggravating and mitigating factors
- Psychiatric assessment and restoration of competency to be executed
- Medical assessment and treatment of condemned prisoners
- Psychiatric evidence at the clemency stage
- Physical examination in preparation for execution
- Administration of sedation or use of other clinical methods to overcome prisoners' physical resistance to the execution process
- Assistance with or conduct of the execution
- Certification of death
- Removal of tissues or organs for transplantation

This section now proceeds to identify some of the particular dilemmas for health professionals at some of the stages in the process of capital punishment.

2.1. Assessing competency to stand trial

It is one of the most firmly embedded principles in Anglo-American jurisprudence that an 'incompetent' defendant may not be put to trial. So "when a psychologist or psychiatrist examines a capital defendant and pronounces that defendant fit to proceed to trial, it might be argued that such professional has become an active participant in the capital punishment process".[13]

This stage of is more complicated if information obtained in the course of the competency assessment is later used at the sentencing stage to support imposition of the death penalty on the basis that the defendant is dangerous and, as in some US states, the statutory aggravating circumstance, such as that "the defendant would commit criminal acts of violence that would constitute a continuing threat to society"[14] is met. At least in the U.S.A., following the decision in *Estelle v Smith* (1981) 451 US 454, this should no longer happen unless, prior to the assessment, the defendant is "informed of his right to remain silent and the possible use of the statements".

Even more ethically objectionable is the prosecutor seeking a competency assessment "as a means of gaining discovery" of potential evidence and so the psychiatrist is acting largely as a prosecution 'investigator'.[13] Even where the psychiatrist does not set out to assist the prosecution in this way, there is a risk that "information gathered from the defendant … might provide leads for the prosecution or other mental health experts to uncover incriminating and/or aggravating evidence that could be used at trial or sentencing".[13] It has been suggested that a safeguard is for the psychiatrist to "maintain objectivity at all times, carefully limit his or her inquiry, opinion and report to the narrow issue of competency, and make every effort to avoid disseminating information that could be used against a capital defendant at other stages of the litigation".[13] However, this may be difficult to achieve if, the psychiatrists have to give evidence as to what the defendant told them about their involvement in the alleged offence.

2.2. Restoring competency to stand trial

Where incompetency to stand trial arises from a reversible or treatable mental disorder it is generally the case that the defendant is admitted to a psychiatric facility for treatment intended to restore competency. No ethical issue arises in a non-capital case as the health professionals involved are exercising their usual therapeutic functions. It is a different matter when the outcome of successful treatment is the restoration of competency and so the actions of health professionals make it more likely that a defendant will stand trial, be convicted and be sentenced to death. But a failure to provide such treatment could constitute a failure to do good, i.e. by relieving mental suffering, and harm could result if an innocent defendant is delayed in, or prevented from, going to trial and being acquitted. Ethically even more contentious is the situation in which the court orders treatment to restore competency. In some countries treatment is given, involuntarily, to restore competence.[15]

2.3. Verdict participation

It is in relation to trial issues of mental state at the material time and the determination of criminal responsibility that psychiatrists are most often required to give opinion evidence in capital cases.[15]

The psychiatrist who gives evidence at the request of the prosecution in a capital case, and whose evidence is used to disprove a defence that might reduce the crime to a non-capital one, is violating the tenet of 'do no harm'. However, it has been argued that the ethical position of the psychiatrist as an expert witness may be different when they are acting outside their usual professional role.[16] Rappeport (quoted by Eastman and McInerney[1]) suggests that the forensic psychiatrist abandons the therapeutic dimensions of psychiatric practice when going to court and functions as an evaluator or opinion-giver.

Others have argued that psychiatrists should only give evidence for the defence in capital cases.[17] Although their ethical position may appear less contentious, information obtained by them may be used by the prosecution to argue for the imposition of the death penalty. In *Penry v Lynaugh* (1989) 492 US 302, the US Supreme Court held that the appellant, who was mentally retarded, with an IQ of 50–65, organic brain damage and a history of considerable physical and emotional abuse as a child, should not be spared the death penalty because his mental condition was held to increase the probability of dangerous behaviour in the future. There is also the risk that the psychiatrist instructed by the defence may not persuade the court of the presence of mental disorder and thereby define its absence[1] making conviction for murder more likely.

It is not a simple matter of doctors opting out of giving opinions in capital cases. Non-participation in capital cases by psychiatrists ethically opposed to participation in death penalty cases would leave the field open to those with a bias favouring capital punishment. Also doctors have a civic duty to perform:

> *the offices, required from them as citizens qualified by professional knowledge, to aid the execution of public justice.*[18]

The AMA goes into more detail; doctors have a duty "to assist in the administration of justice and in ensuring that individuals are treated fairly and punished only when appropriate" (quoted in Brown et al., 2006[15]). If, on such a basis, participation by doctors is generally accepted at this stage, and also at the preceding stages, as Eastman and McInerney[1] observe, "then the making of an exception in relation to capital charges requires specific differentiation". They identify two possible grounds for doing so: the application of a broader definition of non-maleficence as being rightly applicable specifically in relation to judicial killing; and the heightened "significance of any inter-rater unreliability or any invalidity of constructs which might be inherent in psychiatric evidence" given that death is so severe and final a punishment.

2.4. Sentencing and psychiatric evidence as to mitigating and aggravating factors

A mitigating factor is "any aspect of the offense that the defendant proffers as a basis for a sentence less than death" (*Lockett v Ohio* (1978) 438 US 586 at 604). In many jurisdictions, and often in compliance with statutes, the sentencer also has to consider aggravating factors such as "the heinous nature of the crime, the past criminal record of the defendant, and the defendant's future dangerousness".[13] Psychiatrists who examine defendants with these issues in mind, as happens in most jurisdictions, "are direct participants in the death penalty process (and) (i)n at least some cases, their testimony has the potential for swaying the sentencing authority to impose a sentence of death or to spare the defendant's life".[13]

Experts instructed by the prosecution clearly face difficult ethical questions, not least because, in opining as to the dangerousness of the defendant, they are, "(i)n effect, telling the sentencing authority that the state has good reason to execute the defendant"[14] thus contravening the injunction to do no harm. Also, by relying on research of questionable accuracy with regard to predictions of dangerousness,[19,20] they violate the "ethical obligation to render judgments that rest on a scientific basis"[14] and justify the accusation that "the routine prediction of long-term dangerousness, even if genuinely believed to be accurate by the clinician, might constitute a breach of ethical conduct".[21] In their support, it has been argued that "the healer's responsibility extends beyond the individual patient to society as a whole".[14]

It has been argued that if psychiatrists decline to testify at the request of the prosecution, and, as a consequence, the defendant is sentenced to life imprisonment, no harm is done to either the defendant or society[13] but this does not take into account the suffering endured by the life sentenced prisoner.

At first glance, the ethical position of the psychiatrist instructed by the defence appears less problematic. By referring to what the defence intends to identify as mitigating factors, for example, mental retardation, genetic endowment, childhood adversity, destabilising life circumstances or mental disorder falling short of being sufficient to found a defence to a charge of murder so as to persuade the sentencer to stop short of imposing the death penalty, the expectation of the psychiatrist will be that only good can come of their efforts and no harm will be done. However, it has been observed that:

> *(I)f the defense chooses to introduce mental health testimony in mitigation (or exculpation), it thereby opens the door not only to testimony by any experts who were permitted to evaluate the defendant at the behest of the prosecution but also to other mental health evidence that has been obtained.*[22]

The suggestion that precluding the prosecution from using any mental health evaluations carried out for the defense in a capital case,[22] has been recognised as a step in the right direction but far from a solution to the ethical problem.[13] So it has been suggested that "(a)s long as the testimony of a health professional increases (or has the potential to increase) the likelihood that a capital defendant will be sentenced to die, such testimony must be regarded as arguably unethical".[13] However, where, as in the U.S.A., guilt and penalty are decided by the same jury, the evidence given unsuccessfully by the psychiatrist at the guilt phase of the proceedings may be used against the defendant by the same jury at the penalty phase: "Often hearing about an inmate's psychosis causes jurors to fear that mentally ill prisoners cannot be held safely in prisons, so mental illness can become an aggravating, rather than a mitigating factor".[23]

2.5. Psychiatric assessment and restoration of competency to be executed

In 1986 the U.S. Supreme Court 'constitutionalised' the prohibition, recognised for eight hundred years or so in Anglo-American law, against the execution of the "insane" on the basis of violation of the 'cruel and unusual punishment' prohibition of the Eighth Amendment to the U.S. Constitution (*Ford v Wainwright* (1986) 477 US 399). It is therefore almost unavoidable that health care professionals, primarily psychiatrists and psychologists, should be asked to assess death row inmates seemingly suffering 'insanity' and asked to restore the mental competency of those who have been found to be 'insane'.

Although psychiatric opinions are critical, but not dispositive, in that the ultimate decision is made by the court, it has been held that "(t)o render a clinical judgment which has the practical effect of authorising the execution of a convicted capital defendant is clearly contrary to the fundamental ethical commitments of psychology and psychiatry to healing and the relief of human suffering".[24]

Insofar as the US Supreme Court has not offered specific guidance on what constitutes competence to be executed, the psychiatrist who becomes involved carries an added burden. Their opinion, as to what the criteria of competency should be, can in itself increase or decrease the likelihood of the death penalty being carried out. This has been called a 'hard' decision for psychiatrists.[25] According to Showalter (quoted by Eastman and McInerney[1]) "the main issues distil down (somewhat crudely) to 'the dual loyalties' problem, that is, the forensic psychiatrist's dilemma between pursuit of the protection of the rights of the individual versus the protection of society at large". Thus, in order to ensure that the prisoner is not misled by the belief that doctors are always beneficent, the psychiatrist must make his own attitude to capital punishment clear as part of, or in addition to, explaining the nature and purpose of the assessment.

With regard to compulsory treatment with medication to restore competency, at least one court has settled the issue by declaring that this violates the prisoner's due process rights and by concluding that "a physician's prescription and administration of antipsychotic drugs to a prisoner against his will, pursuant to the order of a state court or other government official, for purpose of carrying out the death penalty, does not constitute medical treatment but forms part of the capital punishment sought to be executed by the state" (*Louisiana v Perry* (1992) 610 So.2d 746 (La.) at 753).

This judgment does not resolve the dilemma where the prisoner gives valid consent to treatment to restore competency for execution. This is because prison doctors and psychiatrists usually have a contractual and ethical obligation to provide medical care to prisoners, yet notwithstanding the short-term benefits of doing good by relieving the prisoner of their mental illness, they arguably do a greater harm by rendering a prisoner fit to be executed. Indeed a failure to do so could amount to "a dereliction of the accepted duty to treat" but this is in direct conflict with "the implied, indirect, imposition of harm which will arise thereby".[1] Additional difficulties that have been identified include disclosures made in the course of treatment being used in further competency assessments and the effect on the public perception of mental health professionals who are seen as preparing prisoners for execution.[1]

It has been suggested that where the choice is between providing an effective treatment that results in the prisoner's death and refusing to provide such treatment, "the latter course of (in) action is the ethically proper one".[24] However, this does not address the problem that "denying treatment to the willing psychotic death row inmate may well prolong that inmate's psychopathology and mental distress, thus arguably violating the physician's ethical duty to relieve the suffering of his or her patient".[13] Rather, it has been suggested that rapid treatment of a mentally disturbed prisoner may give him or her more time to prepare for their inevitable execution.[26] Nor does refusing to treat the mentally disturbed condemned prisoner deal with the adverse effect on the penal or therapeutic milieu that results from leaving prisoners or patients untreated and the practical problem of how they should be managed.[11]

Radelet[23] argued forcibly to a committee of the British Medical Association in London in 1990 that giving an opinion as to fitness for execution is an appropriate role for medical practitioners:

> *When a severely psychotic death row inmate faces execution, what would happen if the most ethical and humane psychiatrists declined to help him on the grounds that they did not want to become involved? Only the meanest and most prosecution-prone psychiatrists would do the evaluations. Any boycott would be partial since there would be no way to enforce the ban. Indeed, it could be argued that ethical problems would arise for those physicians who refuse to assist defendants who need psychiatric testimony to convince a judge that they are incompetent for execution. At the same time, a physician who evaluates a prisoner and feels that the prisoner probably does meet the criteria for competence may be more ethically justified in telling the courts that he or she cannot render a firm opinion (i.e. one can never be absolutely certain of competence) than in testifying that the proof of competence is conclusive (italics in original).*

A similar point has been made by Ferris[27]:

> *More important is a consequentialist objection to the notion of psychiatrists absenting themselves from death row. This is simply that in a country where increasing numbers of defendants are being sentenced to death and spending an average of some 10 years on death row (where psychiatric morbidity is high) substantial numbers of people who need it will be deprived of expert psychiatric care. To these prospective patients, the knowledge that the psychiatrists have departed with their ethical integrity intact may be of cold comfort.*

2.6. Medical assessment and treatment of condemned prisoners

Condemned prisoners who are anxious about their impending execution may request sedatives, tranquillisers or hypnotics. It has been asserted that the prescription of such "represents the appropriate and humane care that physicians have traditionally provided for all their patients" and that this is "the only stage at which [non-psychiatric] physicians' participation in the execution process is acceptable".[8] Likewise the AMA allows "the physician (to) use medical or personal skills to comfort the condemned person".[5]

2.7. Psychiatric evidence at the clemency stage

2.7.1. Executive clemency or mercy

> *has its origins in the colonial system under which the Governor, as the monarch's representative, considered whether, in a capital case, the death penalty imposed by the judge in every case of murder should actually be carried out and did so by reference to confidential reports from the trial judge.*[28]

The right to seek a pardon, clemency or commutation of sentence exists in most jurisdictions and has a basis in both the International Covenant on Civil and Political Rights and UN Safeguard No. 7: "Anyone sentenced to death shall have the right to seek pardon or commutation of sentence. Amnesty, pardon or commutation of the sentence of death may be granted in all cases of capital punishment".[3]

Psychiatric evidence, because it covers many of the same sorts of mitigating factors considered in an appeal against sentence, often forms part of the case for clemency. However, a difficulty arises for the psychiatrist who sets out to provide a balanced report that may reveal not only mitigating but also aggravating factors. The latter may be seized upon by the clemency committee and used to justify a recommendation to the executive that the death penalty should be upheld. This was a problem faced by the writer in the case of Mariette Bosch.[2] However, it is arguable that a psychiatric report prepared at this stage does not have to include the aggravating factors when, at least in the USA, clemency proceedings are "nothing more than 'a right to ask for mercy'" and due process is absent.[3] The legal authority for this is in *Ohio Adult Parole Authority v Woodard* (1998) 523 US 272, where the court held that the "heart of executive clemency [is] … to grant clemency as a matter of grace"

and relied on an earlier judgment in *Connecticut Board of Pardons v Dumschat* (1981) 452 U.S. 458 to the effect that commutation of sentence was "simply a unilateral hope" and not a due process right. Here the psychiatrist can avoid violating the principle of 'malfeasance' by taking a unilateral or one-sided view of the psychiatric evidence and presenting only that which will increase the likelihood of the application being successful.

2.8. Assistance with or conduct of the execution

It is execution by lethal injection that may particularly involve health professionals in the process of execution itself because, in many of the states of the U.S.A. where this is a permitted form of execution, health professionals prepare the lethal substances and may administer them. The AMA declared in 1980[29] that:

> *A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution.*

However, "several well-documented mishaps underscore the advantages of medical participation"[8] and if a prisoner requests the attendance of a physician to minimise the likelihood of suffering, this is arguably "consistent with the professional norms of beneficence and consent".[8]

2.9. Removal of tissues or organs for transplantation

Up to 90 per cent of the transplant kidneys used in China, and also numerous corneas and hearts, probably come from executed prisoners and, whereas in Taiwan prisoners are said to have consented, in mainland China there is evidence that consent is not given.[23] Consent may be seen as the key but there is a question as to "whether valid informed consent can occur under stresses of death row confinement and an approaching date with the executioner":

> *Just as starving a prisoner might lead the prisoner to 'choose' to eat stale bread, giving death row inmates no means to obtain partial forgiveness or to preserve their dignity might lead inmates to choose to donate organs. However, neither the choice to eat stale bread nor the choice to donate organs can be said to be free.*[23]

3. Discussion

Autonomy, best interests and rights have been identified as the three core concepts in medical ethics.[30]

3.1. Respecting the condemned prisoner's autonomy

If autonomy is the 'first among equals' out of the four principles[31] of medical ethics,[32] it is reasonable to start with autonomy in trying to resolve some of these ethical dilemmas. Kant[33] said that, 'Autonomy is the basis of the dignity of both human nature and every rational nature'.

It has been said that "(a) condemnation to death and life on death row virtually strips inmates of any autonomy"[23] but condemned prisoners should have some autonomy and giving them more autonomy could go some way towards resolving the ethical dilemmas for health professionals in capital raises. The most striking example of the autonomy of condemned prisoners is the choice they have in 10 US states as to whether they should die by lethal injection or electrocution or by the gas chamber, hanging or the firing squad.[29]

Autonomy supports the moral rule of obtaining consent for interventions with patients.[31] So issues arising out of participation in the investigation of capital offences, assessment of competency to stand trial, verdict participation, sentencing and clemency appeals are capable of some resolution if the health professional, in seeking consent to assess a capital defendant, explains that their report on the prisoner, as well as revealing information or evidence that reduces the likelihood of the death penalty being carried out, may also reveal information or evidence that increases the likelihood the death penalty being carried out. The writer uses a consent form that includes acknowledgement of the fact that the report "may refer to weaknesses in my case as well as strengths".[34]

Consent is also the key to many cases of competency to stand trial, waive appeals and be executed. A competent prisoner could be offered the opportunity to make an advance directive to the effect that, in the event that they lost competency, they did or did not want to have treatment to restore competence.

Consent is also relevant to physical examination in preparation for execution, assistance with or conduct of the execution and clinical monitoring during the execution. What if the prisoner has asked a physician to assist? Hope et al.,[30] use the case of 'The trapped lorry driver: a case of mercy killing' to test principles relevant to end-of-life issues:

> *A driver is trapped in a blazing lorry. There is no way in which he can be saved. He will soon burn to death. A friend of the driver is standing by the lorry. This friend has a gun and is a good shot. The driver asks his friend to shoot him dead. It will be less painful for him to be shot than to burn to death.*

Whereas they identify shooting the trapped driver as an act of killing that is not morally permissible if the doctrine of double effect is right, they comment that the doctrine "seems to give priority to the purity of the intention of the bystander at the expense of the suffering of the lorry driver".

In Lewis Grassic Gibbon's novel 'The 13th Disciple'[35] the main character, Malcolm Maudslay, is fighting in the trenches at the end of World War I. Under fire from the German machine guns he sees

> *one figure hung upon the wire with drooping head and arms outflung, grotesquely crucified … It must have been near midnight before the crucified figure on the wire awoke again to the torture of its own torn body and broke into screams and pleadings in a crescendoing hysteria…*

He realises that the figure on the wire is his best friend and

> *For hour upon hour — though they may only have been so many minutes — he seemed to lie and listen to the voiced anguish of the mutilated mind that had once lived and moved and questioned the world and loved him … He rose and took his rifle and limped up the moonlit ravine…*

When minutes later he joins a group of his comrades, one comments, 'There's a poor bastard on the wire there been screaming his guts out. Quiet now.' Malcolm responds, 'I killed him.'

The literature on capital punishment abounds with examples of 'botched executions'. In hanging, if the drop is too short, death may be by strangulation and, if it is too long, the head may be torn from the body. Electrocution can cause flames to shoot from the body with charring of the skin and severe external burning. Lethal injection can go wrong in a number of ways: an inordinate length of time taken to find a suitable vein; a 'blowout' at the connection between the syringe and the intravenous line causing the drugs to squirt across the room; the combination of drugs not just failing to achieve a painless death but causing an excruciatingly painful death, as can occur when the initial dose of sodium pentothal is insufficient to produce unconsciousness and the subsequent injection of pancuronium bromide, a muscle relaxant, causes a masking of the suffering and appearance of tranquility or when the

sodium pentothal is not followed by a saline flush and it crystallises with the pancuronium bromide causing extreme pain.

Given that most executioners have no knowledge of the nature or properties of the drugs or the risks or potential problems of lethal injection, what if a prisoner asks for a doctor, in whom he has confidence, to prevent or relieve suffering by finding a suitable vein or veins, efficiently insert the intravenous line, draw up appropriate quantities of the lethal drugs, administer them in the correct order and at the right time with a saline flush between each and be prepared to act promptly and efficiently in the event that the procedure goes wrong? To paraphrase the comment about the lorry driver, Hope et al.[30] would say that for a doctor, or other health professional, to refuse to take part seems to give priority to the purity of the intention of the health professional at the expense of the suffering of the condemned prisoner. For the fictional Malcolm Maudslay to have ignored the pleas of his tortured friend, they would say that this seems to give priority to the purity of his intention at the expense of his friend's suffering. However, if Beauchamp and Childress[31] are correct when they say that "(r)ightness and wrongness depend on the merit of the justification underlying the action, not on the type of action it is. Neither killing nor letting die, therefore, is wrongful per se…", then the lorry driver's friend and the dying soldier's friend are to be judged by the justification underlying the action, which is to bring their terminal suffering to as swift and as painless an end as possible.

It has been stated however that "(a) request by the prisoner for physician participation would not overcome objections to physician participation".[29] This situation is analogous to that which exists in countries where medical professional bodies and laws or both prevent health professionals from assisting a person's suicide by providing information about methods, prescribing medication for use in the suicide or administering substances to end the person's life. However some countries do allow physician-assisted suicide and in some countries public support for assisted suicide now seems at odds with legislative prohibitions.

Autonomy may also be the key to issues related to the removal from condemned prisoners of tissues or organs for transplantation. Put simply, unless the condemned prisoner has consented, health professionals should not administer drugs or other substances that facilitate the preservation of tissues or organs after death and they should not remove tissues or organs before or after death. However, Radelet[23] has questioned

> *whether valid informed consent can occur under the stresses of death row confinement and an approaching date with the executioner …. his isolation on death row makes it impossible for him to anticipate the costs and benefits of his actions.*

If this is so, and there is an issue as to the validity of the condemned prisoner's consent, the safest position would be to allow tissues or organs to be removed only where prisoners have given such consent before the commission of the capital offence. This would also avoid the concern that allowing condemned prisoners to donate tissues or organs would become "another justification for the death penalty …. We need to execute because we need (otherwise) healthy dead people for body parts and medical research" and "make executions more palatable to trial juries, judges and clemency officials than long imprisonment" so that "eventually more people would be executed".[23]

3.2. The condemned prisoner's right to die with dignity

Oregon introduced a Death with Dignity Act in 1994 and under the Act it is lawful for a doctor to prescribe a lethal dosage of a drug for a terminally ill patient who wishes to end their life but not to involve himself, or herself, in the suicidal act.[36] Switzerland decriminalised assisted suicide in 1942[37] and in recent years a number of British subjects have travelled to the Swiss Clinic run by *Dignitas* in order to end their lives.

Given that "there is no guarantee that any method of execution will ensure that no physical pain is experienced by the person executed"[3] and the Commission on Human Rights is opposed to capital punishment that is carried out in a degrading manner or by particularly cruel or inhuman means,[3] there is also an argument that an autonomous and capacitous condemned prisoner should have a right to die with dignity by way of assisted suicide. The film *Valkyrie* portrays the fate of the military and civilian conspirators who failed in their attempt to kill Adolf Hitler. The military conspirators know that they are going to face the firing squad. The most senior, or one of the most senior, presumably an officer holding the rank of general, asks for a pistol, he is trusted not to use it to shoot his captors and he shoots himself in the head. The other military conspirators are taken away to await the firing squad.

If a capacitous condemned prisoner knows that execution is inevitable, why should they not be allowed the autonomy to end their life with dignity, or some dignity, by way of assisted suicide? Instead of choosing between lethal injection and electrocution, why should the condemned prisoner not choose between assisted suicide and enforced lethal injection or electrocution?

In the leading Canadian case of *Rodriguez v A-G of British Columbia* (1993) 107 DLR (4th) 342 at 413 on assisted suicide, Cory J expressed the opinion:

> *(D)ying is an integral part of living … It follows that the right to die with dignity should be as well protected as any other aspect of the right to life. State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity.*

Why should the condemned prisoner not also have the right to die with dignity, especially when, to paraphrase Cory J, the alternative would be to force on a rational but condemned prisoner, a dreadful, painful death that would be an affront to human dignity? It seems likely that clinics, such as that run by *Dignitas*, have perfected less painful and more efficient means of ending life than the 'protocol' cocktail of sodium pentothal (thiopental), pancuronium bromide and potassium chloride. Assisted suicide need not be as painful and degrading as execution by lethal injection as practised in many states of the U.S.A.

3.3. Acting in the best interests of the condemned prisoner

Autonomy assists little or not at all in the cases of capital defendants who lack competency to stand trial and in the cases of those condemned prisoners who become incompetent for execution and lack capacity to consent to treatment. It may assist if they have made an advance directive as to what should happen if they lose the competency to stand trial, waive their right to appeal or be executed. It does not assist where there is no advance directive. Here, as Beauchamp and Childress[31] suggest: "Where the previously competent person left no reliable traces of his or her wishes, surrogate decision-makers should adhere only to (best interests)". So what are the best interests of the defendant who is incompetent to stand trial? Ewing[13] has argued that treating the incompetent capital defendant does actually benefit the defendant: denying generally efficacious treatment may not only prolong the suffering associated with his or her mental illness, thus violating the tenet of nonmaleficence, but also deny the defendant the opportunity to go to trial, present a defence and possibly be acquitted. He suggests that arguably it is not in the best interests of an incompetent defendant to spend the remainder of their life in a secure psychiatric institution. This is similar to the argument as to whether it is in

the best interests of a capital prisoner to be executed or to spend the rest of their life imprisoned. On a best interests analysis John Stewart Mill[38] argued that 'the short pang of a rapid death' was not really so bad as a life sentence of hard labour. Likewise Jeremy Bentham, also an abolitionist, "believed that life in prison involved more suffering than a few moments on the gallows" but, as Bedeau reasons, by reference to the thoughts and actions of actual death row prisoners, "the vast majority of friends of the death penalty as well as its opponents believe that death is worse than imprisonment".[39] By the same reasoning, it could be argued, albeit less persuasively, that death is worse than incarceration for life in a state of psychosis in a mental institution.

Greater ethical difficulties arise in the case of capital defendants and condemned prisoners who become mentally ill but not so ill, or not ill in such a way, as to deprive them of the capacity to make a decision as to treatment but the courts order that they should be treated. England and Wales is not a capital jurisdiction but section 36 of the Mental Health Act 1983 gives the Crown Court a power to order a defendant to be treated against his or her wishes. This is a power sometimes used to restore a defendant's fitness to plead and stand trial. In a capital case, Ewing[13] has observed that:

> *providing such treatment would seem to be much less ethically defensible, especially where effective treatment will not simply restore competence but might also alter the defendant's demeanour and presentation in ways that undermine a possible defense (such as insanity) or make the defendant appear less sympathetic to the sentencing authority in the event he or she is convicted.*

Ewing[13] regards the position of a condemned prisoner who is incompetent to be executed as a result of psychosis and is willing to accept antipsychotic medication that would alleviate the psychosis as "a much more difficult dilemma" for the physician as:

> *all penal inmates have a right to necessary medical care, including psychiatric treatment, and prison physicians have a legal and ethical duty to provide such care. Moreover, denying treatment to the willing psychotic death row inmate may well prolong that inmate's psychopathology and mental distress, thus arguably violating the physician's ethical duty to relieve the suffering of his or her patient.*
>
> *On the other hand, providing such treatment in this unique context is likely to result in the inmate's death.*

So, to Ewing[24] the appropriate response seems clear:

> *[W]here the healing professional's choice is between (a) providing treatment which relieves psychological suffering but results in the death of an otherwise healthy human being and (b) refusing to provide such treatment, there can be little if any doubt that the latter course of (in)action is the ethically proper one.*

However, this seems over-simple and does not deal with Radelet's objection. Nevertheless, when the principles of beneficence and non-maleficence are in opposition and lack of capacity rules out reliance on autonomy and consent, it probably has to be a 'best interests' approach that guides health professionals through an ethical minefield that simply cannot and should not be avoided by walking on the ethically safe ground and opting out of participation altogether.

3.4. When non-involvement violates the tenet of non-maleficence

There is another argument in favour of the participation by psychiatrists in such contentious stages as pre-trial psychiatric evaluations and assessments of competency to waive the right to appeal or competency to be executed. Radelet[23] has asked:

> *When a severely psychotic death row inmate faces execution, what would happen if the most ethical and humane psychiatrists declined to help him on the grounds that they did not want to become involved? Only the meanest and most prosecution-prone psychiatrists would do the evaluations.*

Indeed it has been observed that: "Predictions of *non*-dangerousness are much more reliable than are predictions of dangerousness, and can often be very useful to capital defendants".[23]

4. Conclusion

Whether there is a limited ethical basis for health professionals being actively involved in capital punishment or in assisting prisoners to end their lives, it is not possible to get away from the potentially detrimental effect that such involvement will have on the 'moral community of medicine' and on the trust the public has in doctors and other health professionals. As has been observed in relation to euthanasia[40]:

> *I never want to have to wonder whether the physician coming into my hospital room is wearing the white coat (or green scrubs) of a healer, concerned only to relieve my pain and restore me to health, or the black hood of the executioner. Trust between patient and physician is simply too important and too fragile to be subjected to this unnecessary strain.*

Indeed, is the health professional who assists a condemned prisoner to commit suicide anything other than a black-hooded executioner? For all that autonomy, consent, rights and best interests are important approaches to the ethical issues, is not the simplest and least controversial approach, at all stages, to accord primacy to the principle of non-maleficence: "Above all, do no harm". It limits the size of the ethical minefield. As Ewing[13] concludes:

> *(T)hose who participate in any aspect of this process bear the personal and professional burden of reconciling their participation with the highest principle of their professions: "Above all, do no harm".*

Notwithstanding the contribution that doctors and other health professionals could make to the more humane delivery of capital punishment by paying greater regard to such principles as autonomy, consent and best interests, for opponents of the death penalty, like this writer, there must be concern that any 'reforms' that do allow the participation of doctors and other health professionals in capital punishment will, as other reforms have done, "(entrench) even deeper what remains of the death penalty, which makes what remains of it more resistant to complete repeal".[39]

That said, as societal attitudes to dying and assisted suicide change, at least in countries where it is legalised, there needs to be a debate as to whether or not condemned prisoners should have the same rights. It is, or should, not be the sentence of the court that they should die with indignity or suffer a prolonged or excruciatingly painful death. Consideration has to be given to the prisoner's limited opportunities for suicide and indeed the particularly undignified, and to some extent unpredictable, effects of attempted suicide by hanging (which often means suffocation) or the cutting of veins or arteries (often with insufficiently sharp instruments).

These are disturbing issues but capital punishment is disturbing. Ethics does not provide the answers. However, ethics can and should inform the public debate that will become more urgent as societal attitudes to dying, assisted suicide and mental capacity evolve.

Likewise, in capital jurisdictions, where opinion as to medical participation in capital punishment is polarised, but equally argued

by reference to accepted principles of medical ethics, the professional bodies should foster appropriate debate, informed by and tested against public opinion, and all necessary steps, legal and procedural, taken to ensure that in every single capital case there is ethical input, including ethical advice for any involved health professionals.

Law reports

Connecticut Board of Pardons v Dumschat (1981) 452 U.S. 458.
Estelle v Smith (1981) 451 US 454.
Ford v Wainwright (1986) 477 US 399.
Lockett v Ohio (1978) 438 US 586.
Louisiana v Perry (1992) 610 So.2d 746 (La.)
Ohio Adult Parole Authority v Woodard (1998) 523 US 272.
Penry v Lynaugh (1989) 492 US 302.
Rodriguez v A-G of British Columbia (1993) 107 DLR (4th) 342.

Conflict of interest

The author has no conflict of interest but declares his opposition to capital punishment on religious and moral grounds.

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